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# HEALTH

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## MONTHLY PROGRESS REPORT

CONFIDENTIAL

DATA AS OF MARCH 31, 1943

9

ARMY SERVICE FORCES, WAR DEPARTMENT

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OFFICE OF THE SURGEON GENERAL

HEADQUARTERS, ARMY SERVICE FORCES, WAR DEPARTMENT

# HEALTH

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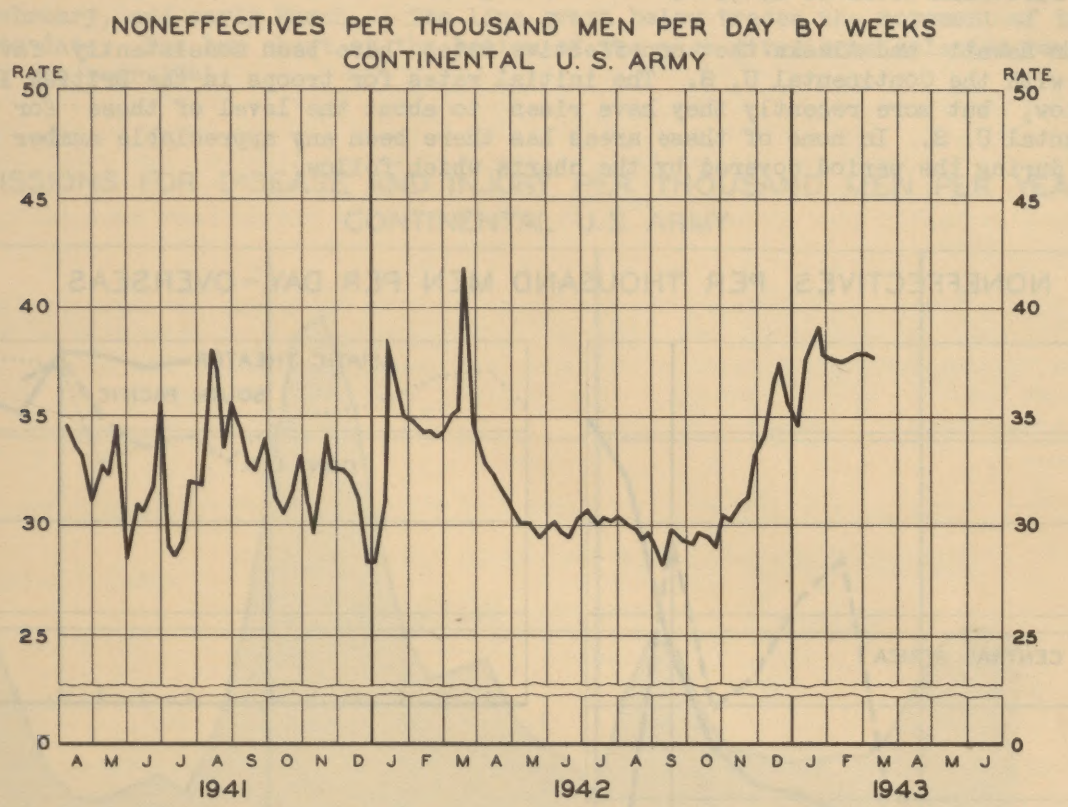
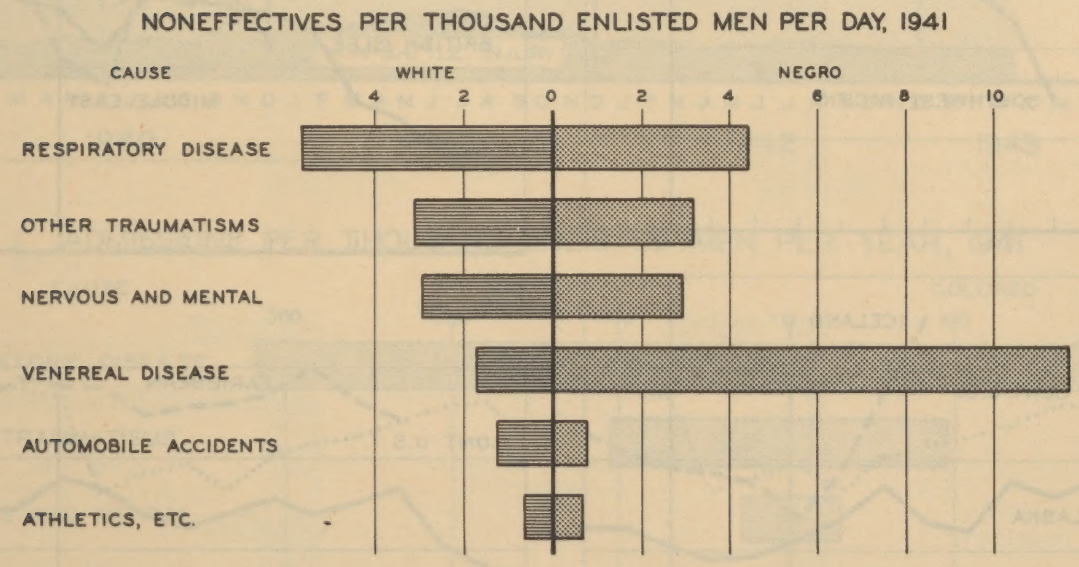
# DISEASE AND INJURY

NONEFFECTIVE RATES, CONTINENTAL U. S.

The average daily non-effective rate among troops in the Continental U. S. was stable at 38 per thousand for the four weeks ending March 13. The line graph below traces the rate from April, 1941, to date. The bar chart at the bottom of the page reveals the relative importance of a few selected components of the average non-effective rate for 1941.



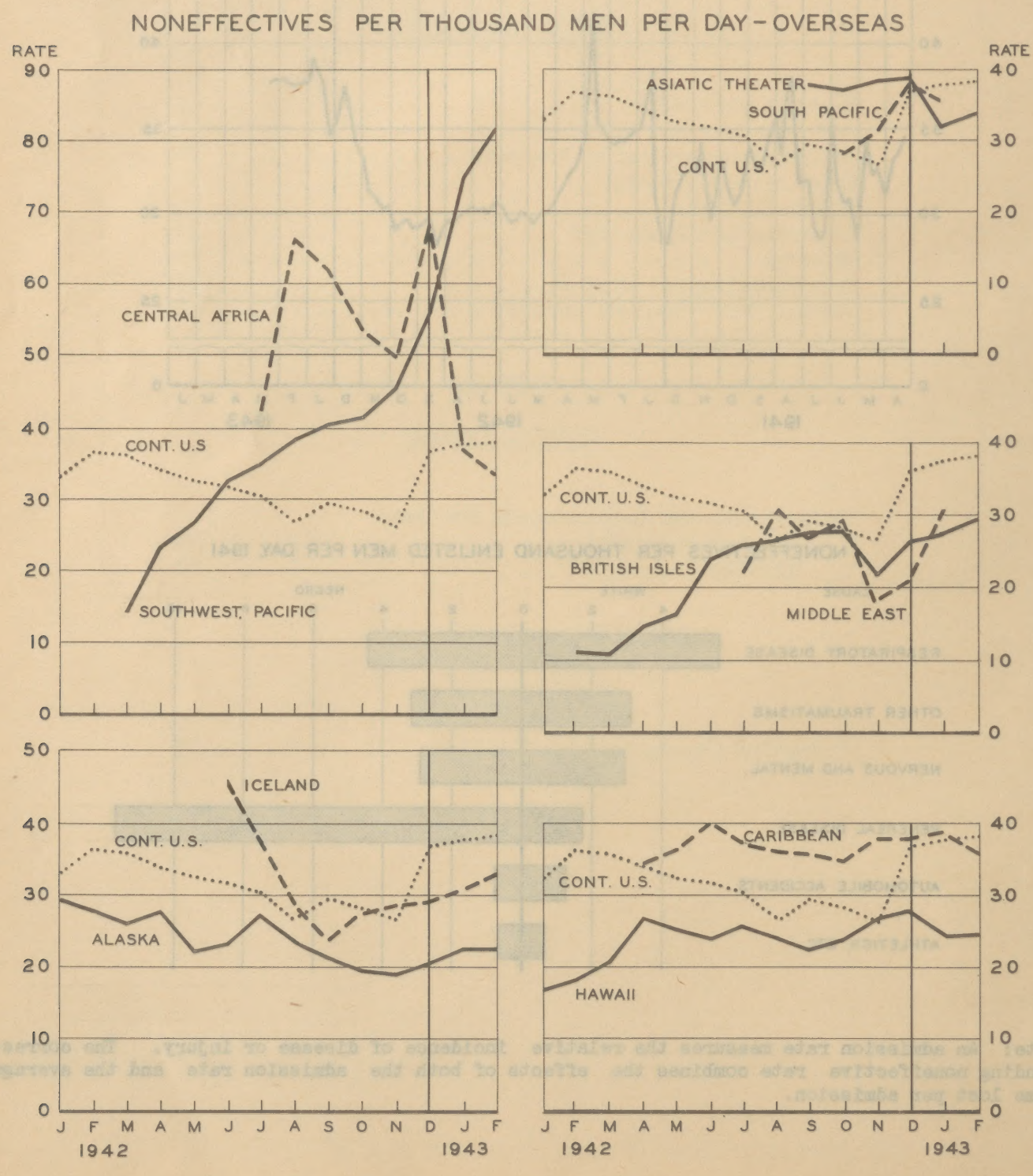




Note: An admission rate measures the relative incidence of disease or injury. The corresponding noneffective rate combines the effects of both the admission rate and the average time lost per admission.

## NONEFFECTIVE RATES OVERSEAS

The average daily noneffective rate for troops stationed in the Continental U. S. is exceeded by the rates for U. S. Army forces stationed in the Southwest Pacific, Central Africa, and the Caribbean. In the Southwest Pacific the rate has been increased by both battle injuries and infectious diseases associated with the progress of operations in New Guinea. In the latter sector the rate has been in the vicinity of 60 per thousand men per day during the first six weeks of 1943.

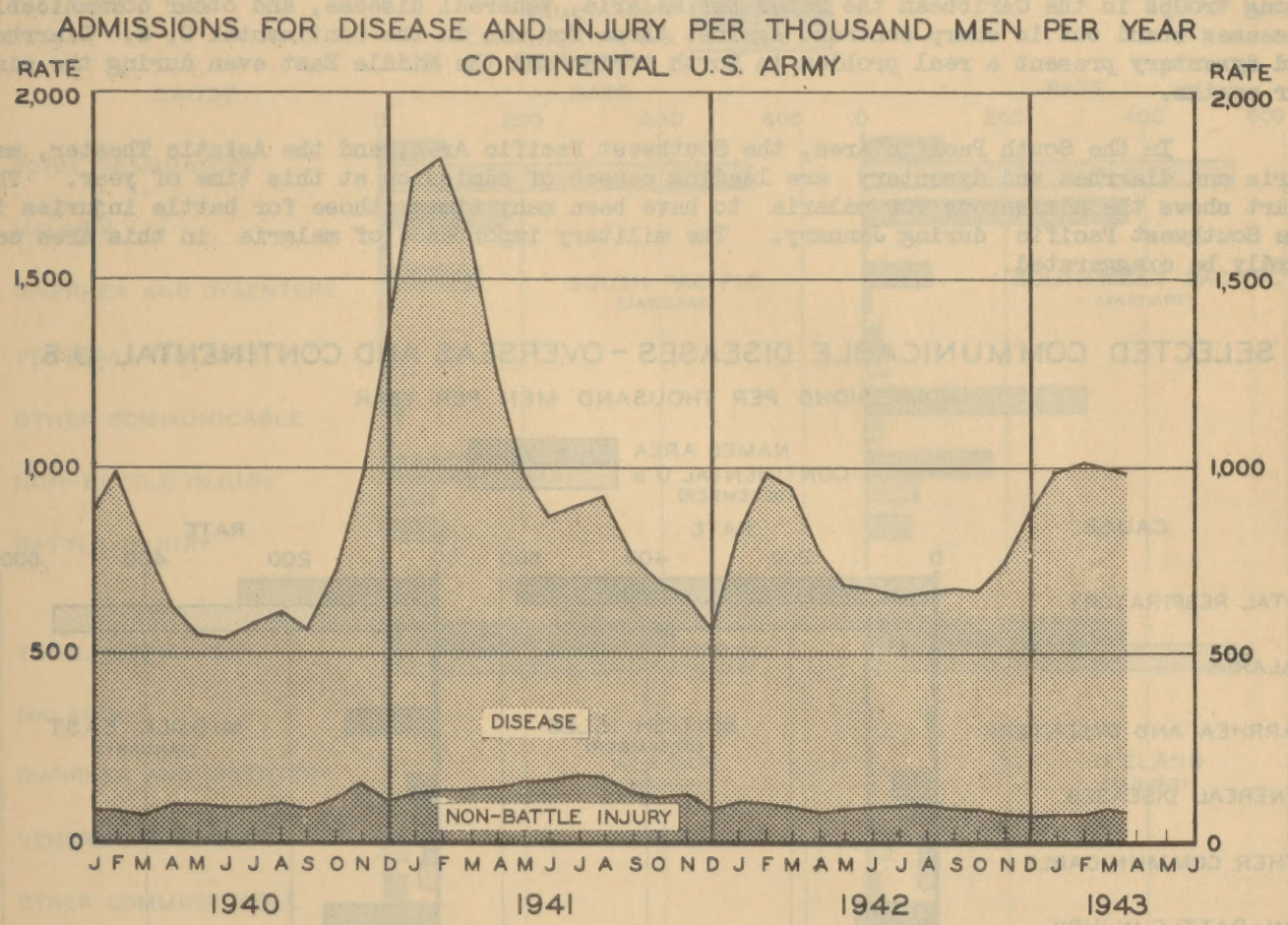
In Hawaii and Alaska the noneffective rates have been consistently favorable in comparison with the Continental U. S. The initial rates for troops in the British Isles were also very low, but more recently they have risen to about the level of those for troops in the Continental U. S. In none of these areas has there been any appreciable number of battle casualties during the period covered by the charts which follow.

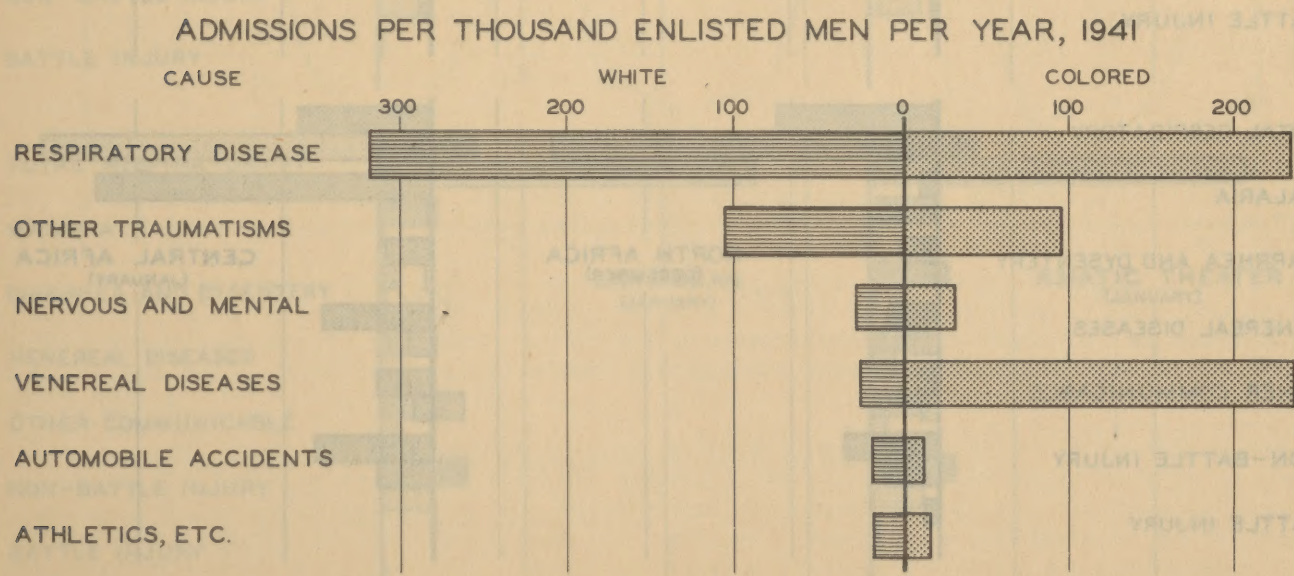


# DISEASE AND INJURY

## DISEASE AND INJURY, CONTINENTAL U. S.

Admissions for disease and injury fell slightly during the first two weeks of March. For January and February the preliminary rates are 990 and 1,004. For the first two weeks of March the preliminary rate is 984. For disease the rates are 918, 922, and 906. Despite a sharp decline in the frequency of respiratory disease, the admissions for all diseases have remained close to the seasonal peak. For injury the rates are 72, 82, and 78 for January, February, and early March. The line graph below traces the movement of these rates from 1940 to date. The bar chart at the bottom of the page gives some selected causes of admission for the year 1941.



# DISEASE AND INJURY

## SELECTED COMMUNICABLE DISEASES

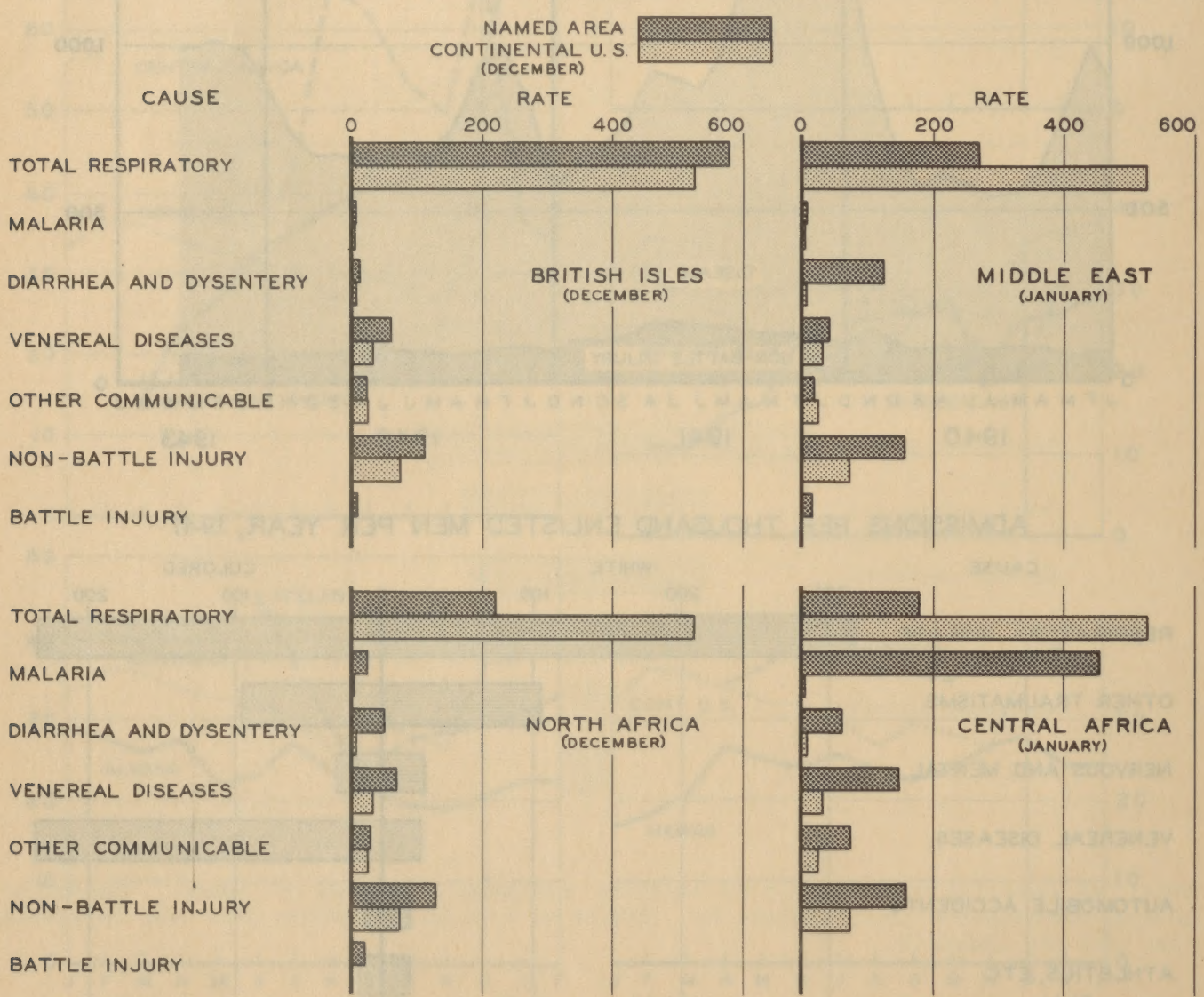
Among the different regions in which U. S. troops are stationed there is wide variation in the relative importance of the more common communicable diseases. The chart below shows the rates for certain areas against the corresponding rates for the Continental U. S. The experience of U. S. Army forces in the British Isles closely parallels that of troops in the Continental U. S. In Alaska and Iceland the pattern of rates is also similar, but both respiratory and venereal infections have been less frequent, and non-battle injuries more numerous, during the winter months.

The Caribbean, North Africa, and the Middle East diverge considerably from the pattern set by the U. S. The incidence of respiratory disease is much lower in all three areas. Among troops in the Caribbean the rates for malaria, venereal disease, and other communicable diseases stand out in sharp contrast against those for men in the Continental U. S. Diarrhea and dysentery present a real problem in North Africa and the Middle East even during the winter months.

In the South Pacific Area, the Southwest Pacific Area, and the Asiatic Theater, malaria and diarrhea and dysentery are leading causes of admission at this time of year. The chart shows the admissions for malaria to have been many times those for battle injuries in the Southwest Pacific during January. The military importance of malaria in this area can hardly be exaggerated.

SELECTED COMMUNICABLE DISEASES - OVERSEAS AND CONTINENTAL U.S.

ADMISSIONS PER THOUSAND MEN PER YEAR

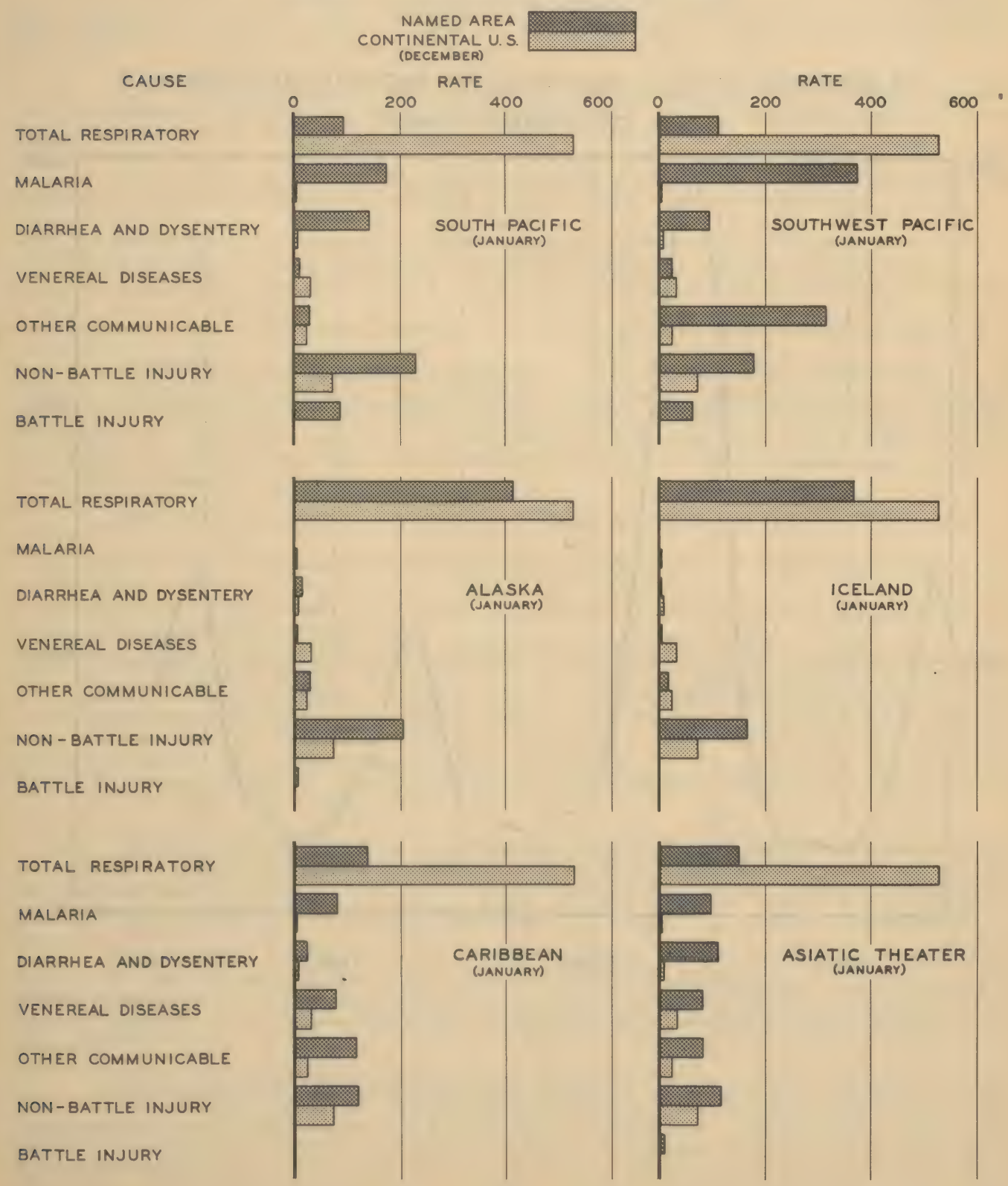


SELECTED COMMUNICABLE DISEASES (Continued)

In every command the admissions for battle injuries during December or January were few in comparison with those for the leading communicable diseases. In all areas during December or January, the rates for non-battle injuries exceeded those for battle injuries by a wide margin. They were also appreciably higher than the corresponding rates for troops stationed in the Continental U. S.

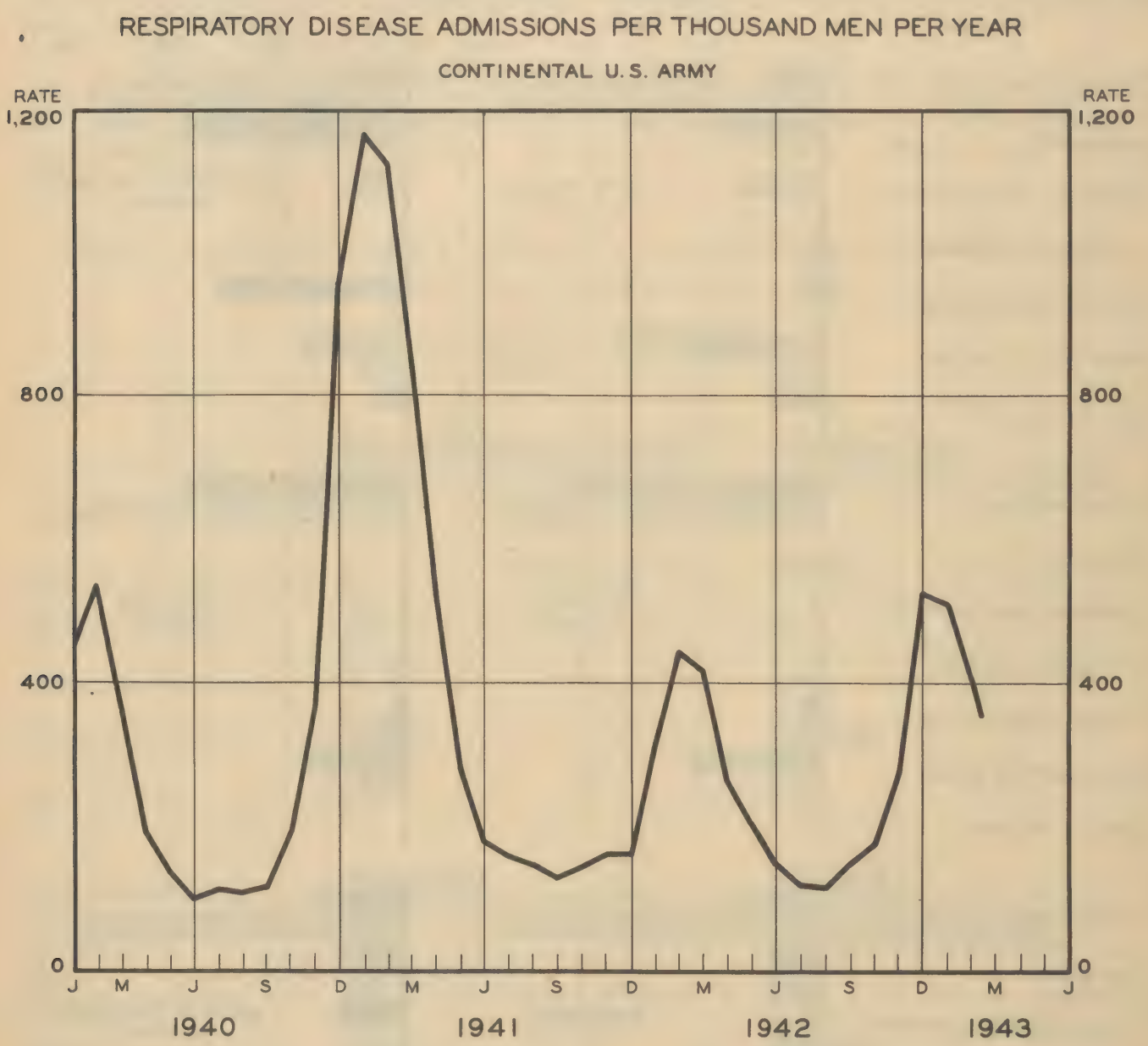
SELECTED COMMUNICABLE DISEASES - OVERSEAS AND CONTINENTAL U.S.

ADMISSIONS PER THOUSAND MEN PER YEAR



RESPIRATORY DISEASE

Admissions for all respiratory diseases have continued their seasonal decline. During the first two weeks of March they were only 355 per thousand per year. Preliminary rates for the complete months of January and February are 507 and 405, both below the final rate of 526 for December. Seen against the background of previous years, the winter peak appears to have been well within the amplitude of expected seasonal variation in non-epidemic years.



VENEREAL DISEASE CONTROL

Venereal disease carries no threat of military disaster as do such epidemic diseases as influenza, malaria, or yellow fever, but month after month syphilis and gonorrhea continue to reduce the effective size of Army units and to burden hospitals and medical personnel. These burdens weigh even more heavily in active theaters of operation.

During January 1943 approximately 10,800 new cases of venereal disease developed among troops stationed in the Continental U. S., 4,500 individuals already infected and requiring treatment were inducted, and 201,512 days were lost from duty because of venereal disease. In the course of the year these figures will become even larger. Yet the current attack rate of approximately 25 per thousand strength per year is substantially lower than even the peacetime rate in the years immediately preceding mobilization. In 1940 non-effectiveness from venereal disease was at the rate of 1,350 days lost per year per 1000 men; for January 1943 the corresponding figure was 547.

The venereal disease control program of the Army includes two principal features; (1) the prevention of infection among military personnel; and (2) the proper medical care of infected personnel in order to make them available for duty.

The control of venereal disease is primarily a problem in preventive medicine. The incidence of venereal disease in a command depends largely upon three factors:

a. The frequency of extra-marital sexual exposures by members of the command;
b. The proportion of these exposures unprotected by adequate prophylaxis; and
c. The proportion of infected women among those to whom members of the command are exposed.

Ordinarily all these factors are operative and control measures must be directed toward each.

REDUCTION IN THE FREQUENCY OF EXPOSURES. Some men will avoid extra-marital sexual exposure under any circumstances, and others will habitually be promiscuous. Probably the majority of the men will be occasionally exposed, and the frequency of their exposure will be determined by a great many factors. If the number of exposures in a large command is halved in a given period of time, the risk of venereal disease will be correspondingly affected, other factors remaining the same.

The following specific measures are designed to reduce the number of exposures:

a. Instruction in the nature of venereal disease and in the importance of avoiding exposure.
b. Provision of wholesome recreational facilities for such substitute activities as athletics and entertainment.
c. Limitation of the activities of professional prostitutes and other promiscuous women. Although this is primarily a problem for civil law enforcement agencies, effective repression can be obtained only with the full support of military authorities. Where local law enforcement machinery is ineffective, the May Act may be invoked to bring Federal law enforcement agencies into the picture. The May Act has been invoked in two areas, with indifferent success.
d. In extreme instances, placing undesirable establishments "off-limits" and limitation of over-night and weekend passes.

REDUCTION IN THE NUMBER OF EXPOSURES UNPROTECTED BY PROPHYLAXIS. Properly utilized, venereal disease prophylaxis is effective in a high proportion of cases, but not all. The combined use of mechanical and local chemical prophylaxis is recommended. Field trials with sulfathiazole by mouth are also being made.

Prophylactic stations are not meeting the needs of the present-day, mobile army. Prophylaxis must be taken to the soldier, not the soldier to prophylaxis. With this in view pocket prophylactic kits have been developed and made readily available to the soldier. Extensive research is in progress in order to discover more acceptable and effective prophylaxis agents.

REDUCTION IN THE NUMBER OF SOURCES OF INFECTION: The sources of infection for soldiers are mostly among civilians, and the reduction in the number of these sources is largely a responsibility of local, state, and Federal health authorities. But the Army renders substantial assistance by obtaining from the soldier descriptive information concerning the probable source of his infection. Such information is transmitted to the appropriate health authority. Civil health agencies then attempt to find the infected civilian and to render

her non-infectious. This aspect of the program has been considerably handicapped by the lack of adequate quarantine facilities for infected girls.

MEASURES DESIGNED TO IMPLEMENT THE FOREGOING PROGRAM. The program outlined above contains no new element, but during the past year there has been a conscious effort to bring the problem more sharply into the focus of preventive medicine. Although the guiding principle is that continence and self-control not only develop character but also are the only completely satisfactory methods of preventing venereal disease, it is recognized that little can be done to alter the morals and character of the men while they are in the Army. The following steps have been taken, therefore, to implement the foregoing program:

a. Appointment of venereal disease control officers. The responsibility for venereal disease control rests upon the commanding officer, and upon the surgeon as his advisor. However, there is considerable work attached to studying the details of a local situation and applying corrective measures. Experience has shown that good results flow from the delegation of this work to medical officers with special training. These men determine why rates are higher in one organization than in another, where and under what circumstances soldiers are becoming infected, the availability of prophylaxis facilities, and the adequacy of educational efforts. At each post a medical officer is designated as venereal disease control officer, the duties of which he may perform on a full or part-time basis depending upon the magnitude of the problem. In addition consultants in venereal disease are assigned to major headquarters of the Army Service Forces, the Army Ground Forces, and the Army Air Forces.

b. Education. Increasing efforts are being made to "sell" venereal disease control to the soldier through instruction and repeated reminders. Posters, pamphlets, film strips, movies and short talks are utilized as educational mediums. Stress is laid upon avoidance of exposure and upon the importance of prophylaxis if exposed.

c. Civilian collaboration. The Army has enjoyed good cooperation from civilian health and law enforcement agencies, and the assignment of Army venereal disease control officers has helped in this respect. At the Federal and service command levels effective assistance has been rendered by the U. S. Public Health Service and by the Social Protection Section, Federal Security Agency.

d. Punitive measures. An effort is being made to discourage the use of punitive measures in the control of venereal disease. It is believed that punishment makes very little contribution to prevention, and that it too often promotes concealment with attendant self-treatment. This is particularly dangerous in flying personnel, for infected men thus continue on flying status.

## NEW PROBLEMS FOR 1943

THEATERS OF OPERATIONS. The chief problem in venereal disease control is the protection of troops in foreign theaters. The magnitude of the problem varies tremendously. The rates are low in the far northern theaters. In Australia the problem compares with that in the United States. In the British Isles, the Caribbean, the South Atlantic, North Africa, and India rates tend to be high and often excessive. The single most important step in dealing with the problem in such areas is to assign venereal disease control officers to study the local situation and to give undivided attention to control measures. Such specialists have been assigned to all the major theaters of operation.

WAAC Personnel. The WAACs will soon comprise a cross-section of the young women of this country and it can be anticipated that the same medical and social problems will be encountered. Some venereal disease will certainly occur. Since the incidence of these diseases can be more accurately determined for military than civilian personnel, it should not be surprising if rates for the WAACs will appear comparatively high. Control measures will have to be developed in accordance with the seriousness of the problem. Education and instruction in sex hygiene are basic requirements.

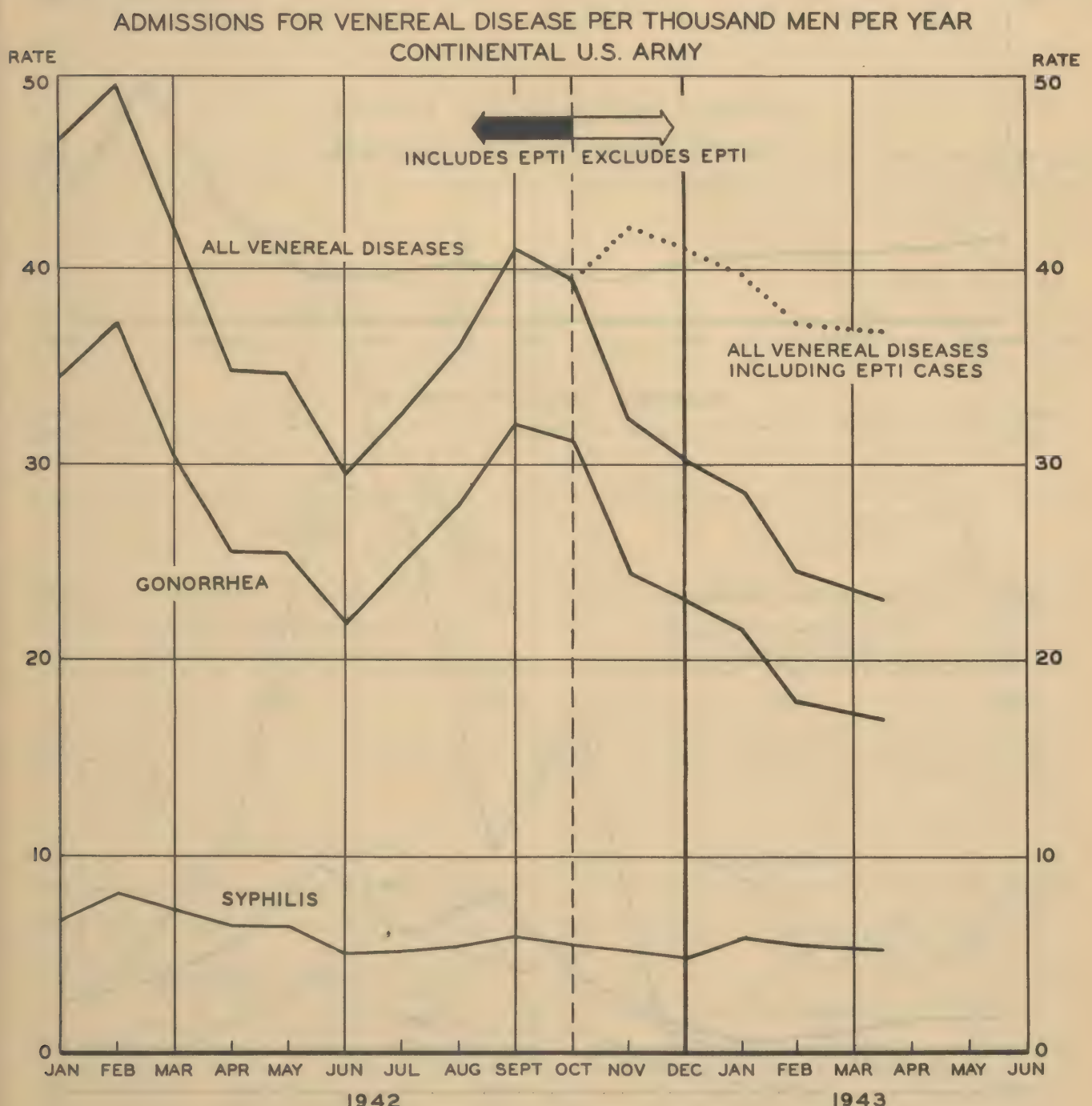
The Specialized Training Program. The Army will soon assume responsibility for large numbers of young men in colleges and universities. The same principles of venereal disease control will be applicable with particular emphasis upon instruction in the nature of venereal disease and in methods of prevention.

SUMMARY. The venereal disease control program of the Army is based upon principles of preventive medicine, and each preventive measure is designed to break a link in the chain of infection. Provisional data indicate that the attack rate of these diseases has declined during the past two years.

VENEREAL DISEASE

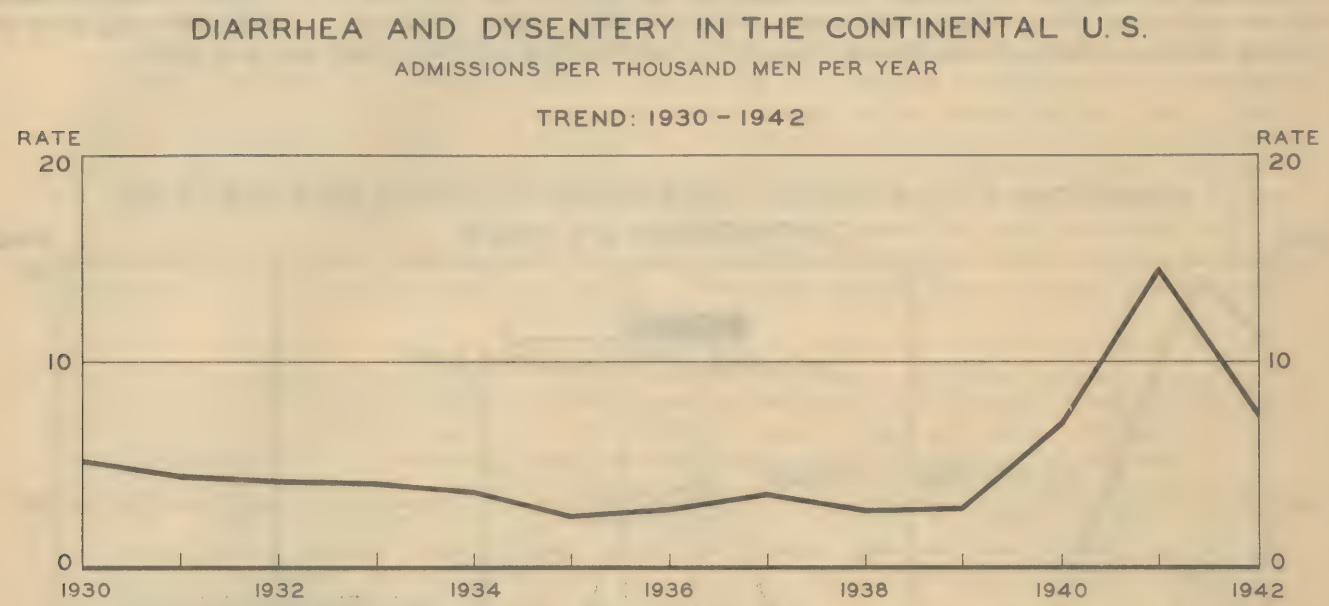
Statistics on venereal disease among troops in the Continental U. S. are complicated by the induction of infected men. In the chart below the rates through October include cases of infection contracted prior to induction (EPTI) or to reporting to active duty. For November and thereafter, the rates exclude EPTI cases and thus more accurately measure the chance of infection among men under full military discipline. The apparent rise of late summer and early fall must be discounted in large part.

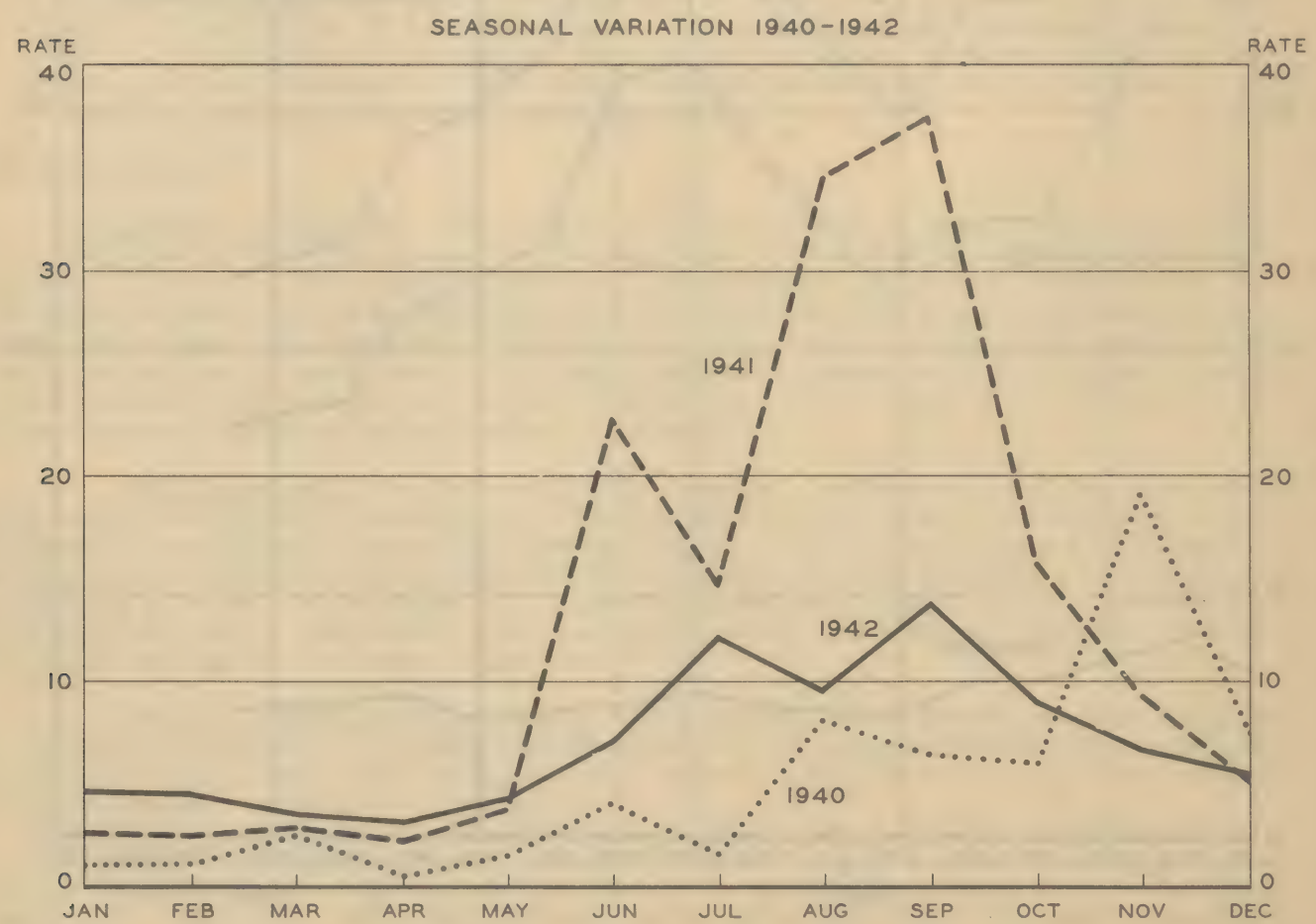
For January and February the rates were 28.7 and 24.5 for all venereal diseases (without EPTI cases) and for the first two weeks of March the rate was 23.2. For gonorrhea the rates were 21.5, 17.9, and 17.0, and for syphilis 4.9, 4.5 and 4.3. The dotted extension of the top line gives the total rate with all EPTI cases included. This rate has also declined slightly from the November peak of 42 admissions per thousand men per year.



## DIARRHEA AND DYSENTERY

In permanent camps and stations equipped with modern sanitary facilities and observing sanitary regulations, the soldier runs only a small risk of contracting diarrhea or dysentery. For the ten years ending 1939 the rate for troops in the Continental U. S. ranged from 2.5 to 5.2. In 1940 it advanced to 7.0, and in 1941 to 14.5 as hundreds of new camps were constructed and the training program took men out into the field. In 1942 the rate of admission declined sharply to about the 1940 level.



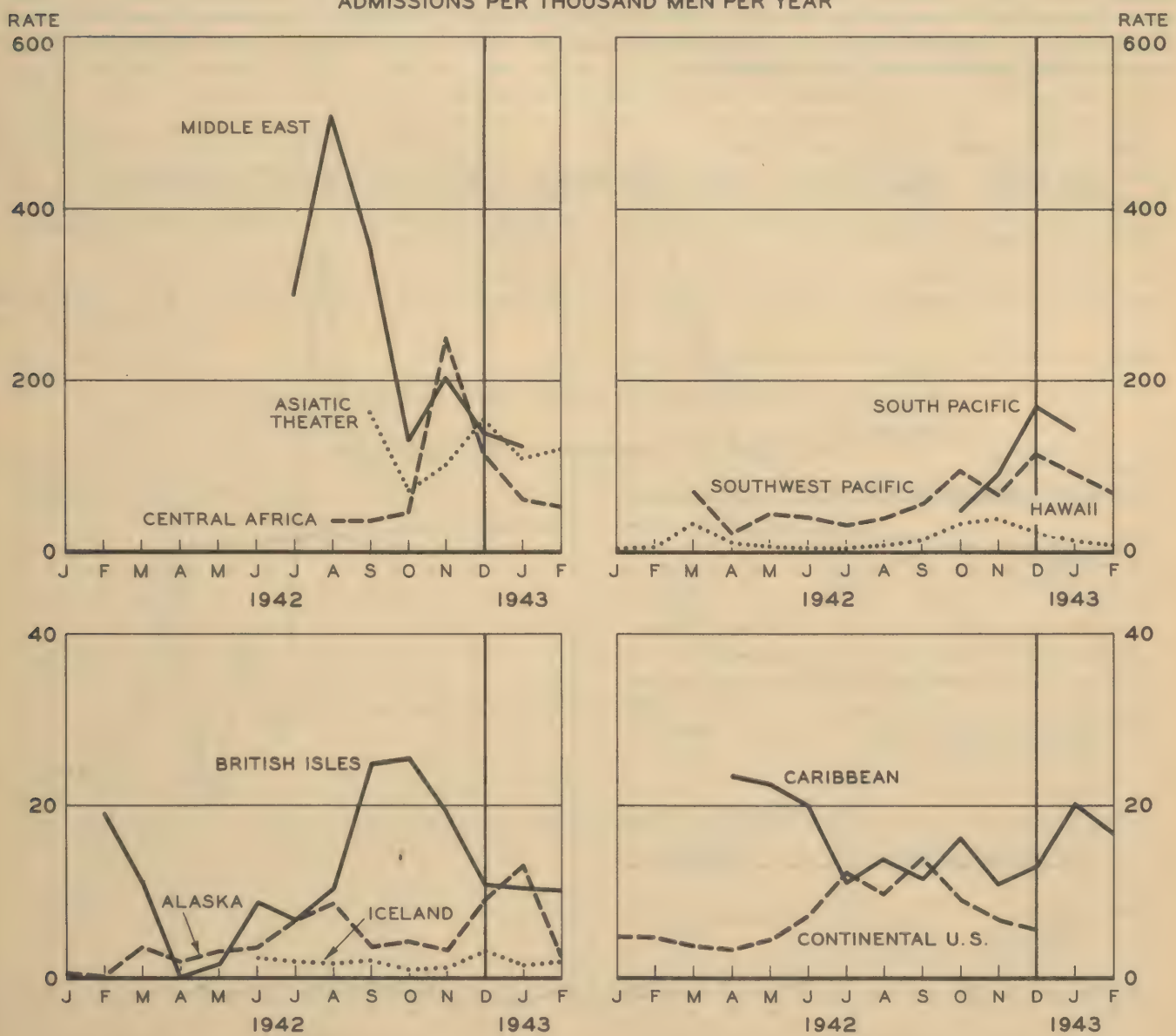
DIARRHEA AND DYSENTERY (Continued)

Under field conditions diarrheas and dysenteries may present a real danger. Unless individual and mass precautions are rigorously observed, diarrhea and dysentery may greatly impair the working and fighting efficiency of even seasoned troops. The greatest incidence among troops in World War II has occurred in the Middle East, where the initial rates of 300 to 500 have recently fallen almost to 100 admissions per thousand strength per year. The rapid fluctuations characteristic of the rates for the Middle East, Central Africa, and the Asiatic Theater may be ascribed in part to small strengths. The general order of the rates of admission is also high for the South Pacific and the Southwest Pacific, shown in the upper right-hand panel.

With the possible exception of Hawaii, the areas shown in the upper panels are "problem" areas from the standpoint of diarrhea and dysentery. The magnitude of their rates is such that the experience of other regions cannot be shown well on the same scale. For this reason the lower two panels carry a scale which is ten times that used for the two panels above. The rates for Iceland and Alaska are seen to be considerably lower than those for the British Isles.

DIARRHEA AND DYSENTERY OVERSEAS

ADMISSIONS PER THOUSAND MEN PER YEAR

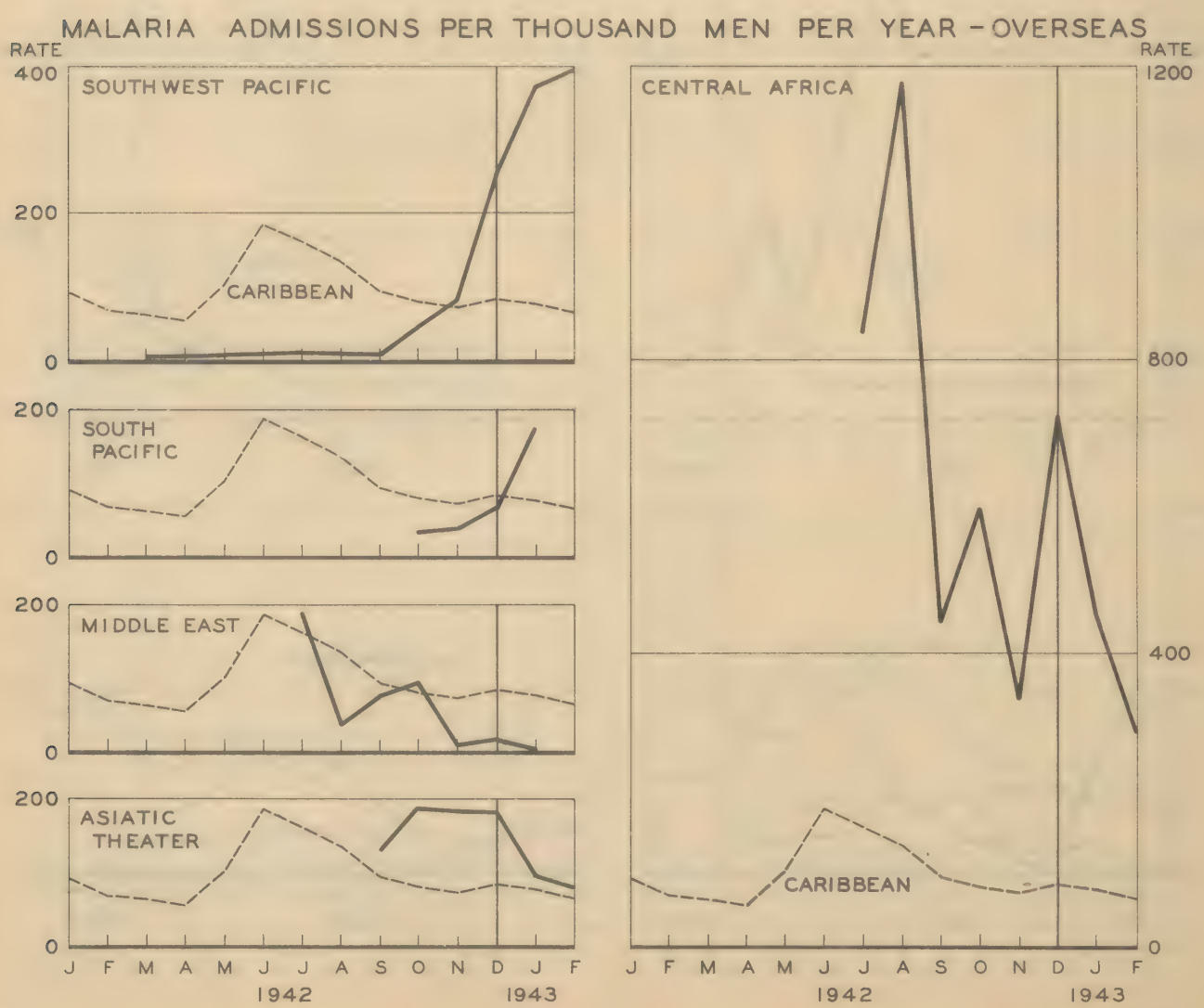


MALARIA

Malaria has been called the most widespread and dangerous disease to which U. S. Army troops will be exposed in World War II. Found throughout the tropical and subtropical regions of the world, malaria constitutes a menace of far-reaching importance to military operations. Because the prophylactic drugs (quinine and atabrine) do not prevent infection but only suppress the clinical symptoms of the disease, its control in the field depends upon diligent antimalarial precautions. The success of this program depends not only upon the proper utilization of specialized equipment, but also upon the degree of malaria discipline instilled in the troops themselves.

In the charts which follow, the 1942 experience of troops of the Caribbean Defense Command has been used as a basis for comparison. U. S. Army troops have long been stationed in Panama and Puerto Rico, an area which is highly malarious. It is immediately apparent that the high rates of this area are paralleled and even exceeded by those of other areas, some of them already active and destined to become even more active. Although the troops in Central Africa (Liberia and the Belgian Congo) have been few in number, the character of the hazard they face is clearly of an entirely different order from that of any of the large areas.

The rates for Australia and New Guinea have increased sharply, partly because of the season, but principally because operations have been extended into New Guinea. The rates for New Guinea alone were about 660 and 765 for January and February, without making any allowance for "undiagnosed fever," much of which undoubtedly is malaria. Reasonable allowances for this factor push the rate well above 1,000. The admission rate for malaria has also risen sharply for the South Pacific Area in recent months, largely because of operations on Guadalcanal. Troops stationed there had a rate of 516 for January, about three times the rate for the entire strength of the area.



NEUROPSYCHIATRIC DISEASE

The present rate of admission to neuropsychiatric wards is 27 per thousand strength per year for troops in the Continental U. S. In 1938, 1.1 civilians out of each thousand in the United States over the age of fifteen were admitted to civilian hospitals for nervous and mental disease. Obviously this does not mean that there is 25 times as much neuropsychiatric disease in the Army as there is in civilian life where psychoneurotics and mild cases of epilepsy, psychopathic personality, and even psychoses, are not hospitalized.

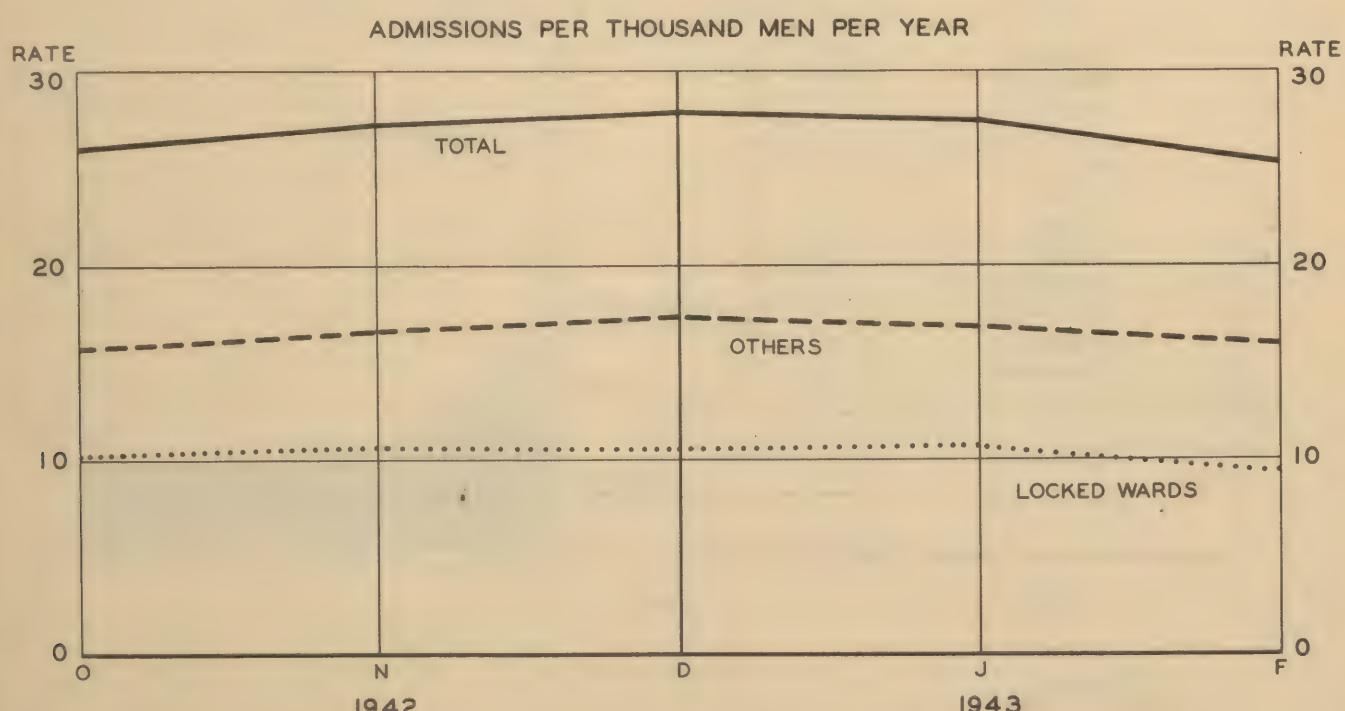
In World War I the rates of admission to Army hospitals for neuropsychiatric disease in the Continental U. S. rose from about 13 during the early months of the war to a peak of 43 seventeen months after its inception. In World War II there has also been a noticeable upward trend, the average rates of 14.3 and 17.0 admissions per thousand strength per year for 1939 and 1940 being exceeded by the present rate of about 27. The chart below gives the rates of admission for all nervous and mental diseases and for patients placed in locked wards for the period October 1942 to February 1943. These rates are rather close to those of World War I ten to fourteen months after the United States entered the conflict.

At present about 2.5 percent of all admissions among troops in the Continental U.S. are for neuropsychiatric causes. About 6 percent of all the patients remaining in Army hospitals in the Continental U. S. are neuropsychiatric in classification. Approximately one-third of the men discharged from the Army for disability are neuropsychiatric cases.

The neuropsychiatric problem in overseas commands can be described only very roughly at this early date. Approximately 15 to 20 percent of the casualties now being returned to the United States are neuropsychiatric in classification. At Guadalcanal 5.7 percent of the admissions cared for by a medical battalion up to February 1943, were neuropsychiatric cases. Next to malaria and battle injury neuropsychiatric disease was the leading cause of admission. If admissions for malaria and all types of traumatism are excluded, 14.4 percent of the admissions were neuropsychiatric. In the entire Southwest Pacific area about 5 percent of all admissions up to January 1943 were neuropsychiatric, the rate of admission being about 60 to 70 per thousand strength per year. In Alaska and the British Isles admission rates for mental disease have been less than 10 per 1,000 strength per year.

In the last war induction centers rejected 2 percent of the examinees. In this war an average of 7 to 8 percent of those examined have been rejected, the present rate being about 6 percent.

NEUROPSYCHIATRIC DISEASE, CONTINENTAL U. S.



## DENTAL INFECTION AND INJURY

The incidence of dental infection (cellulitis, osteomyelitis, and stomatitis) has been relatively low in the Army during the past three years. Although the Dental Corps has lacked necessary personnel, equipment, and supplies, and the magnitude of its task has been multiplied by the voiding of dental standards for induction, there has been no general rise in the average rates of incidence for the more important infections. It is also interesting to note that the mechanization of the Army has not increased the frequency of fractured jaws. More intensive operations overseas will undoubtedly cause this rate to rise. The following table gives the rates for certain individual diagnoses for the past three years:

DENTAL DIAGNOSES PER THOUSAND MEN PER YEAR

| Diagnosis | 1940 | 1941 | 1942 | |
|---|---|---|---|---|
| | Total Army | Total Army | Total Army | Overseas |
| Stomatitis, Vincent's | 26.8 | 29.1 | 31.7 | 10.3 |
| Stomatitis, other | 26.3 | 2.7 | 2.1 | 1.2 |
| Cellulitis | 2.0 | 3.1 | 2.1 | .8 |
| Fracture of Jaws (a) | 1.4 | 1.4 | .9 | .5 |
| Cysts | .8 | .8 | 1.5 | .5 |
| Osteomyelitis | .1 | .2 | .2 | .1 |
| Tumors (b) | .1 | .1 | .1 | .1 |

(a) For 1942, 21 percent were in the maxilla (upper jaw), and 79 percent in the mandible (lower jaw).
(b) Only benign tumors were reported.

Vincent's stomatitis, or "trench mouth", is a potentially epidemic and disabling disease which has been under excellent control by virtue of good diet and oral hygiene. The rate of 10 admissions per thousand strength overseas is well below that of 36 for troops stationed in the Continental U. S., perhaps because of lesser contact with civilian sources of infection. However, certain overseas units have already reported high rates and the overseas rate will undoubtedly rise as combat conditions interfere with oral hygiene and the maintenance of an optimum dietary regime. Monthly rates are shown below for 1942:

VINCENT'S STOMATITIS, ADMISSIONS PER THOUSAND MEN PER YEAR, 1942

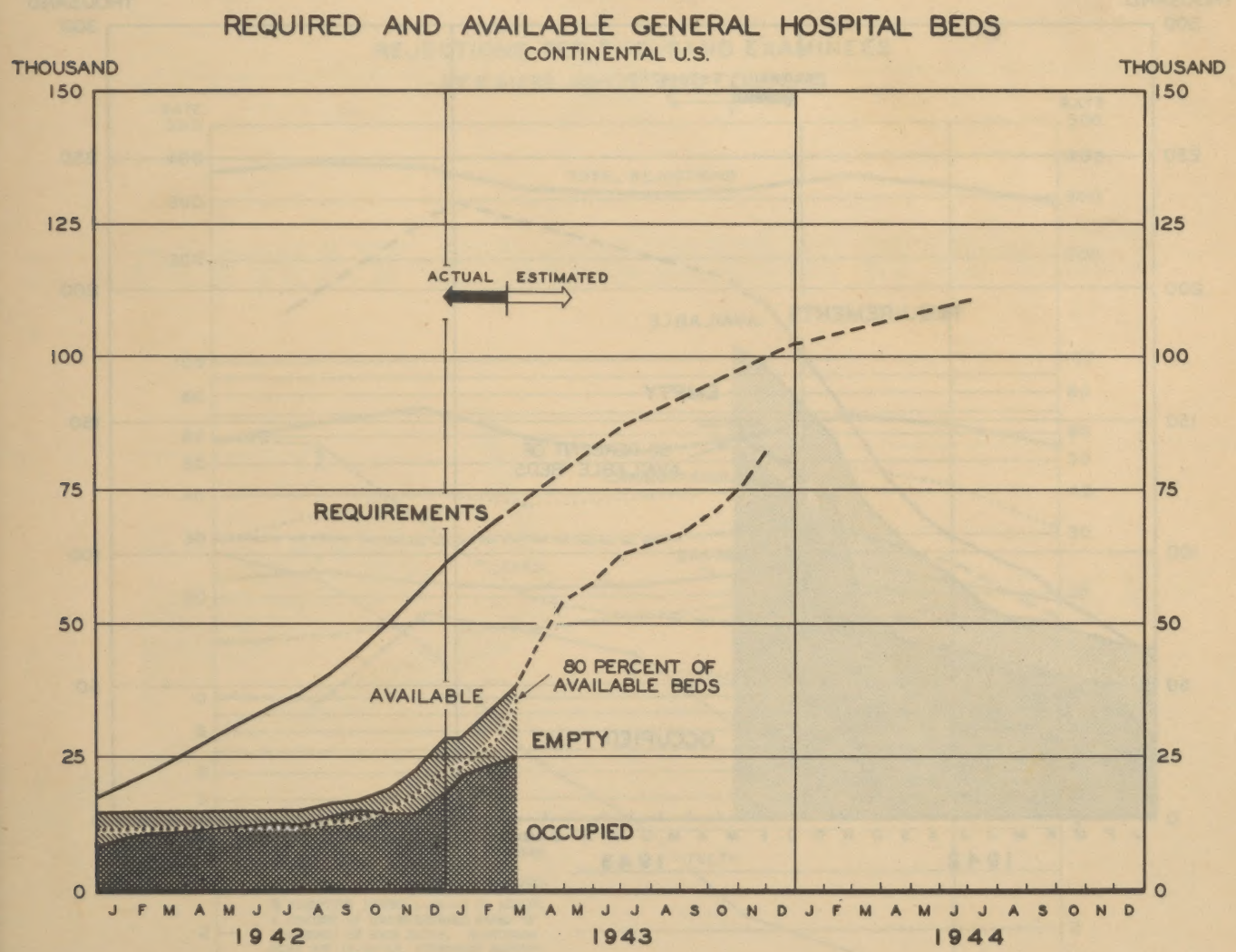
| Month | Total Army | Continental United States | Overseas |
|---|---|---|---|
| January | 43 | 47 | 18 |
| February | 35 | 37 | 18 |
| March | 34 | 35 | 19 |
| April | 20 | 19 | 29 |
| May | 26 | 30 | 10 |
| June | 28 | 32 | 7 |
| July | 28 | 32 | 2 |
| August | 29 | 35 | 4 |
| September | 37 | 44 | 7 |
| October | 35 | 42 | 7 |
| November | 26 | 35 | 7 |
| December | 34 | 37 | 17 |
| The Year | 31.7 | 36.1 | 10.3 |

UTILIZATION OF AND REQUIREMENTS FOR BEDS IN GENERAL HOSPITALS

The requirements for beds in general hospitals are calculated at 1 percent of all troops in the Continental U. S. plus 1.7 percent of all troops overseas. The estimated needs for the period January 1942 to June 1944, are shown in the chart below. The line of projected availability reflects construction in progress, and will be revised as new sites are selected and construction begun. Attainment of the present schedule would provide 82,500 normal beds by the end of November, about 82 percent of the requirements for that date.

Since the Army enjoyed excellent health during 1942, and since overseas action requiring evacuation of patients was minimal, no penalty attached to the failure to meet the calculated requirements. The number of occupied beds is shown by the bottom solid line. The broken line close to it represents the limit of normal utilization without overcrowding, since at any one time about 20 percent of the normal beds cannot be used because they are located in the "wrong" wards. When more than 80 percent of the beds are occupied, it indicates that emergency beds have been crowded into corridors and solaria, or that patients have been placed in expansion barracks.

The number of normal beds available in general hospitals increased from 34,000 on February 13 to 38,000 on March 13. On the latter date the percentage utilization was 66, slightly below the 69 reported for February 13th.

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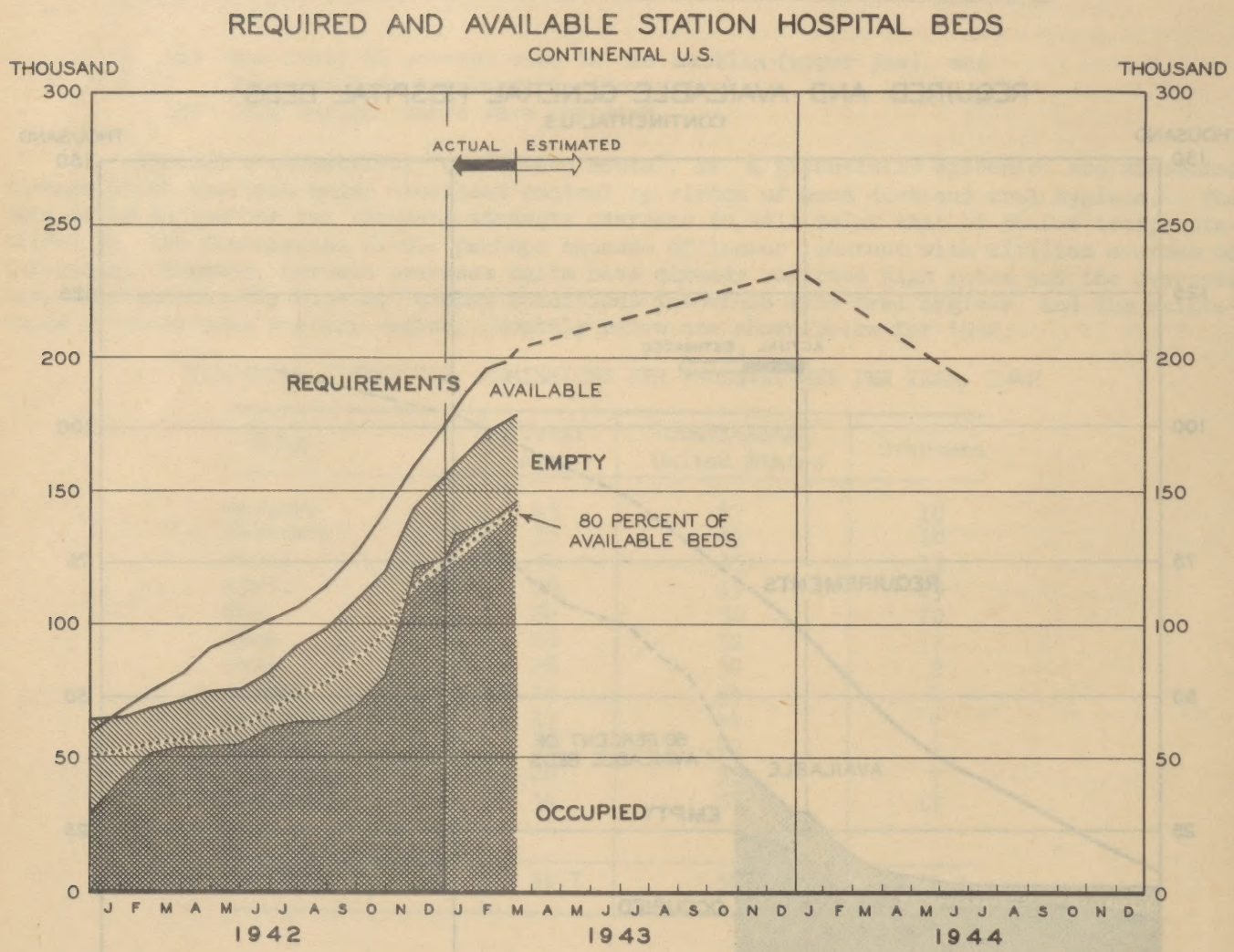
UTILIZATION OF AND REQUIREMENTS FOR BEDS IN STATION HOSPITALS

The requirements for beds in station hospitals in the Continental U. S. are calculated on the basis of 4 percent 1/ of the strength of the troops to be stationed here. The uppermost line on the chart below gives the estimated need for beds in station hospitals from January 1942, to June, 1944. Since the last report this curve has been revised to accord with changes in the number of men to be stationed overseas. The other lines show the number of occupied beds, the total number of available beds, and 80 percent of the total number of available beds (to indicate average utilization without overcrowding).

The number of normal beds available advanced from 172,400 on February 13 to 179,400 on March 13. On the latter date about 82 percent of the normal beds were occupied. This slight degree of overcrowding should be relieved by a seasonal decline in the rate of admission to hospitals.




1/ For the months from December 1942 through March 1943, an additional one percent has been authorized. This increment is to be obtained by utilizing barrack capacity, and only in exceptional cases by constructing new wards. It is not, therefore, regarded as an increase in normal bed capacity.

## INDUCTION STANDARDS

The general health of the Army and the proportion of men fit for combat duty depend in part upon the physical standards for induction. As the strength of the armed forces increases, it becomes increasingly difficult to adhere to the most rigorous standards, but no wholesale revision has yet become necessary. Although the most sensitive index to any change in the criteria of selection would be a running inventory of the characteristics of inducted men at the time of examination, the rates of rejection for medical causes also provide information of considerable value.

The chart below is drawn to show the rates at which some of the more important medical causes of rejection have changed since May, 1942. Parallel trends there have the same rate of change. Only the rates for teeth, eyes, and venereal disease have changed very greatly since May, 1942, and in each instance the change has followed an announced revision of standards. In May about two percent of all examinees were rejected for dental causes, and in January, 1943, less than one in a thousand. The early downward trend for eyes was arrested in September but recently has resumed its decline. Since September, 1942, the importance of venereal disease as a cause of rejection has fallen steadily as a result of the decision to accept some infected men for treatment in the Army. In January only the Third and Sixth Service Commands failed to report the induction of infected men under this new policy.

For the other outstanding medical causes of rejection shown in the chart there was not much change until December, 1942, when a general downward trend became manifest. No relaxation of standards has been announced. In fact, on January 20, 1943, they were made even more rigorous in certain respects.

REJECTIONS PER THOUSAND EXAMINEES
BY CAUSE, WHITE AND COLORED